Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MMC OF EAST TEXAS
P O BOX 1447
LUFKIN, TX 75904-0000

Respondent Name
EAST TX EDUCATIONAL INS ASSN

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-10-5242-01

MFDR Date Received
AUGUST 23, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per insurance states denied for timely filing. Health Ins was billed before receiving workers comp ins, please see attached EOB from the health ins. Per Workers comp ins states that they sent a fax on 2.17.10 and mailed workers comp ins information on 2.19.10 to the hospital. The hospital did not receive any workers comp ins information."

Amount in Dispute: $233.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On February 18, 2010 a letter was faxed by our office to Memorial Health Center advising them that patient received treatment in their facility. A copy of the fax confirmation is attached. A follow-up letter was mailed to Memorial Health Systems on 2/19/2010. Our office received the bill from MMC of East Texas, on the above referenced date of service on 06/10/2010. On 06/25/2010, the charges were reviewed and charges were denied as "The time limit for filing has expired.""

Response Submitted by: Claims Administrative Services, Inc., 501 Shelley Dr., Tyler, TX 75701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
02/15/2010	85027, 86850, 86900, 86901, 85027, 76805	$233.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 25, 2010
   - 29 – The time limit for filing has expired.
   - W1 – Workers Compensation State Fee Schedule Adjustment.

   Explanation of benefits dated August 2, 2010
   - 18 – Duplicate claim/service.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/11/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.